IPDR6702 RUN DATE:	02/11/2007			NORTH CAROLINA HECKWRITE SUMMARY REPORT		PAGE:	1	
KUN DAIE.	03/11/2007			CWRITE DATE: 03/13/2007				
				INANCIAL PAYER: NCDMH				<u> </u>
DROUTDER		UTOU DENTA	NUMBER OF				TOTAL	TOTAL
PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL	CLAIMS	CLAIMS
NOTEDER	PROVIDER NAME	2020	DIMERILO	200000000000000000000000000000000000000	DENIALS	DENIALS	FINALIZED	PAID
3404901	SMOKY MOUNTAINM	8599	207	DETAIL NOT COVERED BY COMBINAT				
	H/DD/SAS			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8536	126	ATTENDING PROVIDER TYPE AND SP		400	640	1.00
		6530	120	ECIALTY COMBINATION IS NOT	2	480	647	167
				VALID FOR SUBMITTED BILLING PR				
		79	54	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
3404904	WESTERN HIGHLAN	8505	369	CLAIM DENIED DUE TO INSUFFICIE				
	DS LME			NT BUDGET				
	1	8565	1	SERVICE EXCEEDS THE ALLOWABLE		370	404	34
		+		OF TWO OCCURRENCES PER POP GROUP WITHIN A FISCAL YEAR.	-	 		
						1		
3404910	PATHWAYS	8599	378	DETAIL NOT COVERED BY COMBINAT		1		
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		21	63	DUDITCATE OF CLAIM_SYSTEM				
	1	ļ		DUPLICATE OF CLAIM-SYSTEM	76	782	5024	4139
		†		+	<u> </u>	 		
		8534	57	SERVICE FACILITY LOCATION IS N				
				OT A VALID IPRS ATTENDING				
				PROVIDER. PLEASE VERIFY THE F				
3404912	CATAWBA COUNTYM	8599	21	DETAIL NOT COVERED BY COMBINAT				
	ENTAL HEALT			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		27	20	DIAGNOSIS CODE MISSING OR INVA	C	47	2786	2739
				LID. VERIFY AND ENTER THE CORRECT DIAGNOSIS CODE AND SUB				
î								
		191	5	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404913		8505	3315	CLAIM DENIED DUE TO INSUFFICIE				
3404913	MECKLENBURG COM	6505	3315	NT BUDGET				
	ENTAL HEALT							
1								
		11	532	CLIENT NOT ELIGIBLE ON SERVICE	7	5113	6063	950
				DATE				
		1				1		
	1	670	356	OTHER DIAGNOSIS CODE 4 IS INVA	-			
		-		LID		1		
		<u> </u>						L
3404916	CROSSROADS BEHA	191	14	CLIENT ID NUMBER DOES NOT MATC				
	VIORAL HEAL	1		H PATIENT NAME	-			
i		1			-	 		
		79	13	THIS SERVICE IS NOT PAYABLE TO	C	51	1246	1195
		1		YOUR SUBMITTED BILLING		31	1240	1193
				PROVIDER TYPE AND SPECIALTY IN				
	1	5404	4	SEVERE DUPLICATE: SAME ATTD PR OV/PCODE/TOS/DOS/MOD	1			
		+		0V/1 C0DB/ 103/ D03/ PIOD				
		+				-		
3404917	CENTERPOINT HUM	8505	752	CLAIM DENIED DUE TO INSUFFICIE		1		
	AN SERVICES			NT BUDGET				
	1	11	207	CLIENT NOT ELIGIBLE ON SERVICE	1			
		11	2U /	CLIENT NOT ELIGIBLE ON SERVICE DATE	0	1165	4604	3439
		+						
		1						
	1	8599	118	DETAIL NOT COVERED BY COMBINAT				<u> </u>
	<u> </u>				1			1
				ION OF RECIPIENT, PROVIDER AND				
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				

							TOTAL	TOTAL
PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL	CLAIMS FINALIZED	CLAIMS PAID
3404919	GUILFORD CO MEN	8599	33	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
	TAL HEALTHC			BENEFIT PACKAGE.				
		8536	7	ATTENDING PROVIDER TYPE AND SP				
		8330	,	ECIALTY COMBINATION IS NOT	0	75	1710	1635
				VALID FOR SUBMITTED BILLING PR				
		11	7	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
3404920	ALAMANCE CASWEL	8505	537	CLAIM DENIED DUE TO INSUFFICIE				
	L AREA MH D			NT BUDGET				
		21	75	DUPLICATE OF CLAIM-SYSTEM	0	736	1434	698
		79	38	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
3404921	ORANGE PERSON C	8505	335	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
	HATHAM AREA							
		11	160	CLIENT NOT ELIGIBLE ON SERVICE		_	-	
				DATE	0	830	2652	1822
		143	58	CLIENT ID NUMBER NOT ON STATE				
				ELIGIBILITY FILE				
3404922	THE DURHAM CENT	21	2402	DUPLICATE OF CLAIM-SYSTEM				
	ER							
		8505	731	CLAIM DENIED DUE TO INSUFFICIE	46	3382	5872	2490
				NT BUDGET				
		8800	99	FURTHER PROCESSING NECESSARY,				
				PLEASE CHECK FOR CLAIM ON FUTURE RA'S.				
3404923	FIVE COUNTY MH	3411	54	PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENHANCED				
				BENEFIT SERVICES ON OR AFTER D				
		79	51	THIS SERVICE IS MOT DAVABLE TO				
		79	21	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING	0	226	1356	1130
				PROVIDER TYPE AND SPECIALTY IN				
		191	49	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404925	SANDHILLS CENTE	8599	406	DETAIL NOT COVERED BY COMBINAT				
	R FOR MH/DD			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		21	179	DUPLICATE OF CLAIM-SYSTEM	51	979	7642	6663
		1						
		120	132	CLIENT ID NUMBER MISSING OR IN				
				VALID. ENTER CID AND SUBMIT AS A NEW CLAIM				
3404926	SOUTHEASTERN RE G MENTAL HL	21	110	DUPLICATE OF CLAIM-SYSTEM				
	O MENIALI RE							
		22	70	CEDUTAR DECUTER PRIOR APPROVA				
		23	78	SERVICE REQUIRES PRIOR APPROVA L	0	307	1605	1298
		8599	32	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.		_	_	
3404927	CUMBERLAND CO M	8505	858	CLAIM DENIED DUE TO INSUFFICIE				
	HC HC			NT BUDGET				
		1						
		8599	35	DETAIL NOT COVERED BY COMBINAT	1	917	1526	609
-				ION OF RECIPIENT, PROVIDER AND				
	1	1	-	BENEFIT PACKAGE.				
		5404	9	SEVERE DUPLICATE: SAME ATTD PR OV/PCODE/TOS/DOS/MOD				

							TOTAL	TOTAL
PROVIDER NUMBER		HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENTALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404930	JOHNSTON COUNTY	11	5	CLIENT NOT ELIGIBLE ON SERVICE				
	MNTL HLTHC			DATE				
		21	1	DUPLICATE OF CLAIM-SYSTEM	0	7	90	83
		8535	1	SERVICE FACILITY LOCATION WAS				
				NOT SUBMITTED ON THIS CLAIM. PLEASE RESUBMIT THE CLAIM WITH				
3404931	WAKE CO HUM SVC	11	120	CLIENT NOT ELIGIBLE ON SERVICE DATE				
	BILLING OF			DALE				
		8599	111	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	15	459	4491	4032
				BENEFIT PACKAGE.				
		100	40					
		120	40	CLIENT ID NUMBER MISSING OR IN VALID. ENTER CID AND SUBMIT				
				AS A NEW CLAIM				
2404022		7.7	0.0					
3404933	SOUTHEASTERN CT R FOR MH/DD	11	88	CLIENT NOT ELIGIBLE ON SERVICE DATE				
	I OK PAI/DD							
		0010	70	CLAIM DENIED, SUBMITTED BEYOND				
		8518	72	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR	0	368	7904	7536
				FISCAL YEAR DOS (JULY 1 - JUNE				
		8599	66	DETAIL NOT COVERED BY COMBINAT			_	
		0399	65	ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404934		8599	61	DETAIL NOT COVERED BY COMBINAT				
3404934	ONSLOW CARTERET BEHAV HEAL	0399	61	ION OF RECIPIENT, PROVIDER AND				
	DANKY HERE			BENEFIT PACKAGE.				
		11	19	OF THE MOST BY TOTAL B. ON CHANGE				
		11	19	CLIENT NOT ELIGIBLE ON SERVICE DATE	0	127	429	302
		22	13	SERVICE REQUIRES PRIOR APPROVA				
		23	13	L				
3404935		0	n	*** NO DATA TO REPORT ***				
3101333	WAYNE CO MENTAL HEALTH CTR			NO DATA TO RELOKE				
		0	0					
		0	0		0	0	0	0
			0		0	0	0	0
3404936	WILSON-GREENE M	8505	85	CLAIM DENIED DUE TO INSUFFICIE NT BUTGET	0	0	0	0
3404936	WILSON-GREENE M ENTAL HEALT		85	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET	0	0	0	0
3404936		8505	85	NT BUDGET	0			0
3404936			85	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE	0	0	0	771
3404936		8505	85	NT BUDGET	0			771
3404936		8505	85	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE	0			771
3404936		8505	85	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE	0			771
3404936		8505	85	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC	0			771
	ENTAL HEALT	8505	85	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME	0			771
	ENTAL MEALT	8505	85	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC	0			7711
	ENTAL HEALT	8505	85	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME	0			7711
	ENTAL MEALT	8505	85	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM	0	88	859	
	ENTAL MEALT	8505	85 2 1	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND	0		859	771
	ENTAL MEALT	8505	85 2 2 1	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM	0	88	859	
	ENTAL MEALT	8505 11 11 191 21 8518	85 2 2 1	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT, PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	0	88	859	
	ENTAL MEALT	8505	85 2 1 1 2 2	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMBLIMIT. PRIOR	0	88	859	
	ENTAL MEALT	8505 11 11 191 21 8518	85 2 2 1 1 6	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE THIS SERVICE IS NOT PAYABLE TO	0	88	859	
3404937	ENTAL MEALT EDGECOMBE NASH NOTE HITH C	8505 11 191 21 8518	2 1 1 9 9 6 6	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN	0	88	859	
3404937	ENTAL HEALT EDGECOMBE NASH NOTH HITH C	8505 11 11 191 21 8518	85 2 2 1 1 9 9	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING	0	88	859	
3404936	ENTAL MEALT EDGECOMBE NASH NOTE HITH C	8505 11 191 21 8518	2 1 1 9 9 6 6	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT, PRIOR FISCAL YEAR DOS (JULY 1 - JUNE THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BELLING PROVIDER TYPE AND SPECIALTY IN PROVIDER TYPE AND SPECIALTY O7	0	88	859	
3404937	ENTAL HEALT EDGECOMBE NASH NOTH HITH C	8505 11 191 21 8518 79	2 2 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATTENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT, PRIOR FISCAL YEAR DOS (JULY 1 - JUNE THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BELING PROVIDER TYPE AND SPECIALTY IN PROVIDER TYPE AND SPECIALTY OF 4/113 CANNOT BILL EMHANCED BENEFIT SERVICES ON OR AFTER D	0	18	1089	1071
3404937	ENTAL HEALT EDGECOMBE NASH NOTH HITH C	8505 11 191 21 8518	2 1 1 9 9 6 6	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN PROVIDER TYPE AND SPECIALTY OF 4/113 CANNOT BILL EMHANCED BENEFIT SERVICES ON OR AFTER D ONLY 16 UNITS ALLOWED PER DAY	0	88	1089	
3404937	ENTAL HEALT EDGECOMBE NASH NOTH HITH C	8505 11 191 21 8518 79	2 2 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATTENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT, PRIOR FISCAL YEAR DOS (JULY 1 - JUNE THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BELING PROVIDER TYPE AND SPECIALTY IN PROVIDER TYPE AND SPECIALTY OF 4/113 CANNOT BILL EMHANCED BENEFIT SERVICES ON OR AFTER D	0	18	1089	1071
3404937	ENTAL HEALT EDGECOMBE NASH NOTH HITH C	8505 11 11 191 21 8518 79 3412	2 1 1 9 9 6 6	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN PROVIDER TYPE AND SPECIALTY OF 4/113 CANNOT BILL EMBANCED BENEFIT SERVICES ON OR AFTER D ONLY 16 UNITS ALLOWED PER DAY MITHOUT PRIOR APPROVAL. PLEASE CORRECT THE	0	18	1089	1071
3404937	ENTAL HEALT EDGECOMBE NASH NOTH HITH C	8505 11 191 21 8518 79	2 2 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT, PRIOR FISCAL YEAR DOS (JULY 1 - JUNE THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN PROVIDER TYPE AND SPECIALTY OF 4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D ONLY 16 UNITS ALLOWED PER DAY HITHOUT PRIOR APPROVAL. PLEASE CORRECT THE DETAIL NOT COVERED BY COMBINAT	0	18	1089	1071
3404937	ENTAL HEALT EDGECOMBE NASH NOTH HITH C	8505 11 11 191 21 8518 79 3412	2 1 1 9 9 6 6	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN PROVIDER TYPE AND SPECIALTY OF 4/113 CANNOT BILL EMBANCED BENEFIT SERVICES ON OR AFTER D ONLY 16 UNITS ALLOWED PER DAY MITHOUT PRIOR APPROVAL. PLEASE CORRECT THE	0	18	1089	1071
3404937	ENTAL HEALT EDGECOMBE NASH NOTH HITH C	8505 11 11 191 21 8518 79 3412	2 1 1 9 9 6 6	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL WEAR DOS (JULY 1 - JUNE THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN PROVIDER TYPE AND SPECIALTY IN PROVIDER TYPE AND SPECIALTY OF 4/113 CANNOT BILL EMHANCED BENEFIT SERVICES ON OR AFTER D ONLY 16 UNITS ALLOWED PER DAY MITHOUT PRIOR APPROVAL. PLEASE CORRECT THE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	0	18	1089	1071
1404937	ENTAL HEALT EDGECOMBE NASH NOTH HITH C	8505 11 11 191 21 8518 79 3412	2 1 1 9 9 6 6	NT BUDGET CLIENT NOT ELIGIBLE ON SERVICE DATE CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL WEAR DOS (JULY 1 - JUNE THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN PROVIDER TYPE AND SPECIALTY IN PROVIDER TYPE AND SPECIALTY OF 4/113 CANNOT BILL EMHANCED BENEFIT SERVICES ON OR AFTER D ONLY 16 UNITS ALLOWED PER DAY MITHOUT PRIOR APPROVAL. PLEASE CORRECT THE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	0	18	1089	1071

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404941		0.1	50					
3404941	PITT CO MH/DD/S	21	58	DUPLICATE OF CLAIM-SYSTEM				
	AS CENTER							
		143	29	CLIENT ID NUMBER NOT ON STATE		138	1601	1463
				ELIGIBILITY FILE	U	130	1001	1403
		8599	21	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404942	ROANOKE CHOWANH	8000	22	NO RATE AVAILABLE ON FILE TO P				
	UMAN SERVIC			RICE THIS CLAIM DETAIL				
		21	11	DUPLICATE OF CLAIM-SYSTEM	0	48	1434	1386
		8654	9	ONLY 16 UNITS ALLOWED PER DAY				ļ
		1	-	WITHOUT PRIOR APPROVAL. PLEASE CORRECT THE				
			1	AFFROVAL. PLEASE CURRECT THE				ļ
3404943		8599	75	DETAIL NOT COVERED BY COMBINAT				-
	ALBEMARLE MENTA L HEALTH CE		1.3	ION OF RECIPIENT, PROVIDER AND	1			
	L HEALTH CE	+	1	BENEFIT PACKAGE.	1			
		1	+	- A A PROMPTION .				
		79	33	THIS SERVICE IS NOT PAYABLE TO	15	187	1237	1050
				YOUR SUBMITTED BILLING	13	107	1237	1030
				PROVIDER TYPE AND SPECIALTY IN				
		8535	17	SERVICE FACILITY LOCATION WAS				
				NOT SUBMITTED ON THIS CLAIM.				
				PLEASE RESUBMIT THE CLAIM WITH				
3404944	EASTPOINTE HUMA	8599	13	DETAIL NOT COVERED BY COMBINAT				
	N SERVICES			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
				CLIENT ID NUMBER DOES NOT MATC		2.2		
		191			1	33	4477	4444
		191		H PATIENT NAME	1	33	4477	4444
		191			1	33	4477	4444
				H PATIENT NAME	1	33	4477	4444
		21	4		1	33	4477	4444
			4	H PATIENT NAME	1	33	4477	4444
			4	H PATIENT NAME	1	33	4477	4444
3404946		21	4	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM	1	33	4477	4444
3404946	FOOTHILLS AREAM		4	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT	1	33	4477	4444
3404946	FOOTHILLS AREAM ENTAL HEALT	21	4	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	1	33	44//	4444
3404946		21	4	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT	1	33	44//	4444
3404946		21	104	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	1			
3404946		21		H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	9	164	4477	5241
3404946		21		H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC	9			
3404946		21		H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC	9			
3404946		21		H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER DOES NOT MATC	9			
3404946		21 8599	21	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME	9			
3404946		21 8599	21	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER DOES NOT MATC	9			
		8599 191	21	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE	9			
3404946	ENTAL HEALT TIDELAND MENTAL	21 8599	21	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE	9			
	ENTAL HEALT	8599 191	21	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	9			
	ENTAL HEALT TIDELAND MENTAL	8599 191	21	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE	9			
	ENTAL HEALT TIDELAND MENTAL	21 8599 191 143	21 13 171	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	9	164	5405	5241
	ENTAL HEALT TIDELAND MENTAL	8599 191	21	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND	9	164		5241
	ENTAL HEALT TIDELAND MENTAL	21 8599 191 143	21 13 171	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNETI PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNETI PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELINIT. PRIOR	9	164	5405	5241
	ENTAL HEALT TIDELAND MENTAL	21 8599 191 143	21 13 171	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND	9	164	5405	5241
	ENTAL HEALT TIDELAND MENTAL	21 8599 191 143 8599	13 171 162	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	9	164	5405	5241
	ENTAL HEALT TIDELAND MENTAL	21 8599 191 143	21 13 171	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING STHELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE CLAIM DENIED DUE TO INSUFFICIE	9	164	5405	5241
	ENTAL HEALT TIDELAND MENTAL	21 8599 191 143 8599	13 171 162	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	9	164	5405	5241
	ENTAL HEALT TIDELAND MENTAL	21 8599 191 143 8599	13 171 162	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING STHELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE CLAIM DENIED DUE TO INSUFFICIE	9	164	5405	5241
3404957	ENTAL HEALT TIDELAND MENTAL HEALTH CTR	21 8599 191 143 8599 8518	21 13 171 162	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELINIT, PRIOR FISCAL YEAR DOS (JULY 1 - JUNE CLAIM DENIED DUE TO INSUFFICIE NT BUDGET	9	164	5405	5241
3404957	ENTAL HEALT TIDELAND MENTAL HEALTH CTR NEW RIVER AREAM	21 8599 191 143 8599	13 171 162	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT, PRIOR FISCAL YEAR DOS (JULY 1 - JUNE CLAIM DENIED DUE TO INSUFFICIE NT BUDGET PROVIDER TYPE AND SPECIALTY 07	9	164	5405	5241
3404957	ENTAL HEALT TIDELAND MENTAL HEALTH CTR	21 8599 191 143 8599 8518	21 13 171 162	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNETI PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNETI PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE CLAIM DENIED DUE TO INSUFFICIE NY BUDGET PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENNANCED	9	164	5405	5241
3404957	ENTAL HEALT TIDELAND MENTAL HEALTH CTR NEW RIVER AREAM	21 8599 191 143 8599 8518	21 13 171 162	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT, PRIOR FISCAL YEAR DOS (JULY 1 - JUNE CLAIM DENIED DUE TO INSUFFICIE NT BUDGET PROVIDER TYPE AND SPECIALTY 07	9	164	5405	5241
3404957	ENTAL HEALT TIDELAND MENTAL HEALTH CTR NEW RIVER AREAM	21 8599 191 143 8599 8518	21 13 171 162	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNETI PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNETI PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE CLAIM DENIED DUE TO INSUFFICIE NY BUDGET PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENNANCED	9	164	1561	5241
3404957	ENTAL HEALT TIDELAND MENTAL HEALTH CTR NEW RIVER AREAM	8599 191 143 8599 8518 8505	21 13 171 162 65	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELINIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE CLAIM DENIED DUE TO INSUFFICIE NT BUDGET PROVIDER TYPE AND SPECIALTY OF 4/113 CANNOT BILL ENNANCED BENEFIT SERVICES ON OR AFTER D	9 9	164	5405	5241
3404957	ENTAL HEALT TIDELAND MENTAL HEALTH CTR NEW RIVER AREAM	8599 191 143 8599 8518 8505	21 13 171 162 65	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNETI PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNETI PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING STIELLIMIT, PROVIDER AND ESCHETT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING STIELLIMIT, PROVIDER CLAIM DENIED DUE TO INSUFFICIE NT BUDGET PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENBANCED BENEFIT SERVICES ON OR AFTER D CLAIM DENIED, SUBMITTED BEYOND	9	164	1561	5241
3404957	ENTAL HEALT TIDELAND MENTAL HEALTH CTR NEW RIVER AREAM	8599 191 143 8599 8518 8505	21 13 171 162 65	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE CLAIM DENIED DUE TO INSUFFICIE NT BUDGET PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR	9 9	164	1561	5241
3404957	ENTAL HEALT TIDELAND MENTAL HEALTH CTR NEW RIVER AREAM	8599 191 143 8599 8518 8505	21 13 171 162 65	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE CLAIM DENIED DUE TO INSUFFICIE NT BUDGET PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR	9	164	1561	5241
	ENTAL HEALT TIDELAND MENTAL HEALTH CTR NEW RIVER AREAM	8599 191 143 8599 8518 8518	21 13 171 162 65	H PATIENT NAME DUPLICATE OF CLAIM-SYSTEM DUPLICATE OF CLAIM-SYSTEM DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNETI PACKAGE. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENNETI PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE CLAIM DENIED DUE TO INSUFFICIE NT BUDGET PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENMANCED BENEFIT SERVICES ON OR AFTER D CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	9	164	1561	5241